

# LONG-TERM CARE INFLUENZA-LIKE ILLNESS OUTBREAK FOLLOW-UP REPORT

**Influenza-like illness (ILI):** a cough and fever ( $\geq 100^{\circ}\text{F}$ ) or chills. Influenza is confirmed when an individual has a positive culture or rapid-antigen test for influenza and respiratory symptoms.

**ILI Outbreak:** suspected when three (3) or more cases of ILI are detected on a single unit during a period of 48 to 72 hours. An ILI outbreak is confirmed when at least one resident has a positive culture or rapid-antigen test for influenza.

REPORTER INFORMATION			
FACILITY NAME:			
NAME OF REPORTER:		TITLE/DEGREE:	
ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:
PHONE#:		FAX#:	
FACILITY INFORMATION			
Type of long-term care facility (check only one):			
<input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Assisted Living <input type="checkbox"/> Combined Care <input type="checkbox"/> Other			
Date of Onset of Illness for First Case:		Date of Onset of Illness for Last Case:	
A. RESIDENT INFORMATION			
1. a. Total number of residents in facility during outbreak: _____			
b. If your facility is divided into units or wings, provide the breakdown of residents per unit or wing. Attach additional sheets if necessary.			
<u>Wing</u>		<u># of Residents</u>	
2. Age range of residents (also, median if known): _____			
3. Total number of residents vaccinated during the current flu season prior to outbreak: _____			
B. STAFF INFORMATION			
4. a. Total number of staff in facility during outbreak: _____			
b. If your facility is divided into units or wings, provide the breakdown of staff per wing/unit. Attach additional sheets if necessary.			
<u>Wing</u>		<u># of Staff</u>	
Any staff that work in more than one wing?			
<input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, how many? _____			

c. How many of these staff (*if multiple wings, please provide breakdown for each wing*):

	<u># of Staff</u>	<u>Age Range of Staff</u>	<u># Vaccinated</u>
Work directly with residents			
Have no contact with residents			

### OUTBREAK INFORMATION

7. a. Were any specimens sent to a commercial laboratory for influenza rapid diagnostic testing? ☐ Yes ☐ No

b. If yes, list the name of the laboratory performing the test: \_\_\_\_\_

### TREATMENT INFORMATION

8. Were antivirals used for treatment of residents (*those with ILI symptoms*) during the outbreak? ☐ Yes ☐ No

9. Were antivirals used for prophylaxis of residents (*those exposed, but without ILI symptoms*) during the outbreak? ☐ Yes ☐ No

10. Were antivirals used for treatment of staff (*those with ILI symptoms*) during the outbreak? ☐ Yes ☐ No

11. Were antivirals used for prophylaxis of staff (*those exposed, but without ILI symptoms*) during the outbreak? ☐ Yes ☐ No

### ISOLATION

12. Were residents **with ILI** isolated from other residents? ☐ Yes ☐ No

13. Date first resident(s) with ILI was isolated: \_\_\_\_\_

14. Number of residents with ILI who were isolated during the outbreak: \_\_\_\_\_

### QUARANTINE

12. Were residents **without ILI** quarantined from other residents? ☐ Yes ☐ No

13. Date first resident(s) was quarantined: \_\_\_\_\_

14. Number of residents who were quarantined during the outbreak: \_\_\_\_\_

### COMMENTS

**THANK YOU!!! PLEASE FAX TO (808) 586-4595**

Please fill out the attached sheets. Thank you for your assistance with influenza surveillance in Hawai'i.  
Contact the Hawaii Department of Health's Disease Investigation Branch at **(808) 586-4586** if you have any questions.

**RESIDENTS** INFLUENZA-LIKE-ILLNESS (ILI) TRACKING SHEET (Attach additional sheets if necessary)

Name (Last, First)	Wing or Unit (if applicable)	DOB	Sex	Age	Date of ILI Onset	Date Specimen Collected	Rapid Test Result (if known)	Flu Vaccination (y/n)	Vaccination Date	Fever (°F)	Cough	Sore Throat	Malaise	Chills	Muscle Aches	Diarrhea	Vomiting	Headache	Pneumonia*?	Date Hospitalized* (if applicable)	Mortality*?	Treatment
<i>Ex. Smith, John</i>		<i>4/18/1996</i>	<i>M</i>	<i>7</i>	<i>12/20/2003</i>	<i>12/20/2003</i>	<i>Influenza A</i>	<i>Yes</i>	<i>9/30/2003</i>	<i>102.1</i>	✓	✓	✓					✓	<i>Y</i>	<i>12/24/2003</i>	<i>N</i>	<i>Tamiflu</i>
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\* Please indicate if resident developed pneumonia (clinical diagnosis is sufficient), was hospitalized or died within 2 weeks of ILI onset.

**STAFF INFLUENZA-LIKE-ILLNESS TRACKING SHEET** (Attach additional sheets if necessary)

Name (Last, First)	Wing or Unit (if applicable) / Type of Staff (Nursing, Admin, etc.)	DOB	Sex	Age	Date of ILI Onset	Date Specimen Collected	Rapid Test Result (if known)	Flu Vaccination (y/n)	Vaccination Date	Fever (°F)	Cough	Sore Throat	Malaise	Chills	Muscle Aches	Diarrhea	Vomiting	Headache	Pneumonia*?	Date Hospitalized* (if applicable)	Mortality*?	Treatment
<i>Ex. Smith, John</i>	<i>Wing A / Nursing</i>	<i>4/18/1956</i>	<i>M</i>	<i>47</i>	<i>12/20/2003</i>	<i>12/20/2003</i>	<i>Influenza A</i>	<i>Yes</i>	<i>9/30/2003</i>	<i>102.1</i>	✓	✓	✓						✓ Y	<i>12/24/2003</i>	<i>N</i>	<i>Tamiflu</i>
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